MEDI-CAL UPDATE

Part 2
Billing and Policy
www.medi-cal.ca.gov

Allied Health • Medical Transportation

Ground Medical Transportation Updates

Effective for dates of service on or after September 1, 2006, the following policies regarding ground medical transportation are updated.

Electrocardiograms (ECGs) in Ambulances
CPT-4 code 93005 (electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report) replaces HCPCS code X0022 (ECG in ambulance). ECGs with a three lead rhythm strip are a routine component of ambulance transportation and are not separately reimbursable. Medicare denial of code 93005 will be required for crossover recipients.

Non-Emergency Ambulance Transportation
Individuals with chronic conditions requiring oxygen do not qualify for non-emergency medical transportation by ambulance unless monitoring is required. Such individuals should be transported in a litter van or wheelchair van when all the following criteria are met:

- Cannot use public or private means of transportation
- Clinically stable
- Can transport upright in a litter van or wheelchair van
- Able to self-monitor oxygen delivery system
- No other excluding conditions

This information is reflected on manual replacement pages <u>mc tran gnd 8 thru 11</u> (Part 2), <u>mc tran gnd cd 1 thru 4</u> (Part 2) and <u>medi non hcp 1</u> (Part 2).

Ground Ambulance Mileage Electronic Billing Clarification

Existing policy requires providers to include complete origination and destination addresses when submitting claims for ground ambulance mileage (HCPCS code X0034 or X0216). When billing these services in the Professional ASC X12N 837 v.4010A1 transaction format, the origination and destination may be conveyed one of two ways:

1. As origination and destination information (or other policy requirements) text length may exceed the NTE02 Claim Note byte limitation (Loop 2300), submitters are encouraged to **also** use the Claim Line NTE02 (Loop 2400) to convey the address information.

2. If the byte limitation of these two segments combined is still insufficient to convey the policy information, submitters are encouraged to utilize the PWK segment and link a paper or fax attachment to the claim.

The second option necessitates an Attachment Control Form (ACF), which is used as a coversheet for the supporting paper or fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment.

Providers mailing or faxing attachments for electronic claims must enter the pre-printed ACN on the electronic claim and include the ACF with the attachments sent in the mail or by fax. ACF supplies can be ordered by calling the Telephone Service Center (TSC) at 1-800-541-5555.

Effective July 14, 2006 after 6 p.m., Medi-Cal will implement a third means to convey the origination and destination address information required for ground ambulance mileage billing:

- The origination address may be conveyed in Loop 2310D. If multiple services lines have different procedure modifiers, such as when indicating a multiple leg trip, then the origin location will be in Loop 2420C of the service line used for the previous leg of the trip (i.e., the destination of leg #1 is also the origin of leg #2). For the NM1 (Service Facility Location) qualifier, a code '77' will need to be entered along with the new field information containing the provider name, address 1, address 2 (optional), the city, state and ZIP code.

- The destination address may be conveyed in Loop 2420C. The location specified in each occurrence of this loop indicates the destination consistent with the procedure modifier in SV101-3. For the NM1 (Service Facility Location) qualifier, a code '77' will need to be entered along with new field information containing the provider name, address 1, address 2 (optional), city, state and ZIP code.

Please note that the maximum number of addresses that can be submitted is six.

The *837 Version 4010A1 Health Care Claim Companion Guide* has been updated to reflect this change with this implementation.

For additional billing guidance, refer to the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page and then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link. If you have further questions, call the TSC at 1-800-541-5555, then select Option 16, followed by Option 11 for Computer Media Claims (CMC). Software vendors and out-of-state billers/submitters who bill for in-state providers should call (916) 636-1200, and then select the appropriate prompt.

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2006 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update*.

HCPCS Level II Code Additions

Durable Medical Equipment and Supplies
A4604, A9281, E0170, E0171, E0641, E0642, E0705, E0911, E0912, E1392, E2207 – E2215, E2218 – E2226, E2371, E2372, K0734 – K0737

Orthotic Procedures and Devices
L0491, L0492, L0621 – L0640, L0859, L2034, L2387, L3671 – L3673, L3702, L3763 – L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975 – L3978

Prosthetic Procedures and Appliances
A6513, A6542, A6544, L5703, L5858, L5971, L6621, L6677, L6883 – L6885, L7400 – L7405

HCPCS Level II Codes with Description Changes

Durable Medical Equipment and Supplies
A4632, A6550, A7032, A7033, A8033, E0240, E0463, E0464, E0637, E0638, E0935, E0971, E1038, E1039, K0669

Orthotic Procedures and Devices
L1832, L1843 – L1846, L2036 – L2038, L2405, L3215 – L3217, L3219, L3221, L3222, L3230, L3906, L3923, L8010

HCPCS Level II Code Deletions

Durable Medical Equipment
A6551, E0972, E1019, E1021, E1025 – E1027, K0064, K0066 – K0068, K0074 – K0076, K0078, K0102, K0104, K0106, K0452

Orthotic Procedures and Devices
K0619, K0630 – K0649, L0860, L1750, L2039, L3963

Prosthetic Procedures and Appliances
L8210, L8230

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71	238.72	238.73	238.74
238.75	238.76	238.79	277.30	277.31	277.39	284.01
284.09	284.1	284.2	288.00	288.01	288.02	288.03
288.04	288.09	288.4	288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64	288.65	288.69	289.53
289.83	323.01	323.02	323.41	323.42	323.51	323.52
323.61	323.62	323.63	323.71	323.72	323.81	323.82
331.83	333.71	333.72	333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19	338.21	338.22	338.28
338.29	338.3	338.4	341.20	341.21	341.22	377.43
379.60	379.61	379.62	379.63	389.15	389.16	429.83
478.11	478.19	518.7	519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11	523.30	523.31	523.32
523.33	523.40	523.41	523.42	525.60	525.61	525.62
525.63	525.64	525.65	525.66	525.67	525.69	526.61
526.62	526.63	526.69	528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *	608.23 *	608.24 *	616.81 **
616.89 **	618.84 **	629.29 **	629.81 ** +	629.89 **	649.00 ** +	649.01 ** +
649.02 ** +	649.03 ** +	649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +	649.13 ** +
649.14 ** +	649.20 ** +	649.21 ** +	649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +	649.40 ** +	649.41 ** +	649.42 ** +
649.43 ** +	649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +	649.60 ** +	649.61 ** +
649.62 ** +	649.63 ** +	649.64 ** +	729.71	729.72	729.73	729.79
731.3	768.70 #	770.87 #	770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91	784.99	788.64	788.65

Additions (continued)

793.91	793.99	795.06 **	795.81	795.82	795.89	958.90
958.91	958.92	958.93	958.99	995.20	995.21	995.22
995.23	995.27	995.29	V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31	V58.32	V72.11	V72.19
V82.71	V82.79	V85.51	V85.52	V85.53	V85.54	V86.0 ** +
V86.1 ** +						

Restrictions

*   Restricted to males only
**   Restricted to females only
#   Restricted to ages 0 thru 1 year
+   Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Manual replacement pages reflecting these ICD-9 code updates will be included in a future *Medi-Cal Update.*

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Remove and replace:	mc tran gnd 7 thru 12

Remove:	mc tran gnd cd 1 thru 5
Insert:	mc tran gnd cd 1 thru 4

Remove and replace:	medi non hcp 1/2